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Of Apples and Trees: Adoption and Informed Consent

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Of Apples and Trees: Adoption and Informed Consent

By Ellen Wertheimer[1]

Abstract

This article argues that the doctrine of informed consent should apply to the process of adopting a child. There is substantial evidence that all adopted children are at higher risk of learning disabilities and mental health problems than nonadopted children. The article first summarizes the social science evidence demonstrating these risks and discusses some of the reasons why more extensive studies have not yet been done. The article then turns to the law of informed consent as created and applied in the contexts of medicine and law, and concludes that informed consent doctrine should apply to the process of adoption. Thus, adoption professionals should inform prospective adoptive parents about the risks that adopted children (and their parents) confront.

Introduction

Because this is an article about informed consent, I will begin with a disclosure. When my husband and I adopted our beautiful infant son, we were confident in the belief that this process would make him our son in every respect. If confronted with the maxim that "the apple does not fall far from the tree," we would have responded that our love and commitment would make us the tree that would determine our son's development and future. We would have been wrong. "Neither legal papers nor ritualistic ceremonies change the DNA of the adopted child. Neither do they cancel out his loss [of his biological family]."[2] As the following

[1] [1]Professor of Law, Villanova University School of Law. I am indebted to my research assistant, Lauren Taigue, for her enthusiastic and unflagging work on this article, even though much of her research took her through depressing realms. I also want to thank Richard Redding for his extremely helpful feedback and suggestions, Amy Spare for her assistance in identifying and hunting down sources, Sue Small for her stellar computer skills, and William Ebert for his inspiration regarding the title.

[2] NANCY NEWTON VERRIER, COMING HOME TO SELF: THE ADOPTED CHILD GROWS UP

article demonstrates, an adopted baby, however loved and tended, derives from a biological tree over which no one has any control and which no amount of love and effort can alter. To paraphrase one author: all the nurturing in the world is "no match for a bunch of neurotransmitters."[3] Nor should the effect of the adoption itself be minimized.

Disproportionate percentages of adopted children have learning disabilities and/or mental illness, at a rate far beyond that of the non-adopted population. No one seems able definitively to show why this is. There are several possible reasons, including genetics, the trauma of the adoption itself, and mixtures of the two. Choosing an explanation for why this is the case is beyond the scope of this article, even if there were an explanation available. What matters for purposes of this article is that evidence of these contrasting rates of disability and mental illness exist.

The first part of this article sets forth the existing research on rates of learning disabilities and mental illness in adopted children. The research is sparse and often contradictory. But it is there. There are glaring gaps, and the studies could be more voluminous, thorough, and systematic. The article speculates as to why there is such a paucity of materials and the reasons for the clear difficulties in obtaining access to appropriate study populations.

The second part of the article sets forth the doctrine of informed

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419 (Gateway Press, Inc. 2003).

[3] Bonnie Miller Rubin, *The Fallout from a Less Than Perfect Beginning*, in A LOVE LIKE NO OTHER (Pamela Kruger & Jill Smolowe, eds., Riverhead Books 2005) 116, 124.

consent and its implications for the adoptive process. Adoption agencies[4] are of course under a legal obligation to disclose problematic information that relates to the specific child whose adoption is under consideration. This obligation, enforced through the tort of wrongful adoption, is not the subject of this article.[5] Rather, this article argues that general adoption information–such as the general rates of disability and mental illness in adopted populations–should be disclosed to all prospective adoptive parents. While there is some evidence that "the vast majority of adoptees are well within the normal range of adjustment,"[6] the risks that a particular child will have some form of learning disability or mental illness are significantly higher in adopted children than in nonadopted children. It is these risks that prospective adoptive parents are entitled to know. This information is distinct from the child-specific information that is the subject of wrongful adoption obligations and lawsuits. In addition to any child-specific information, prospective adoptive parents need to know the general risks they are taking on when they adopt a child.

I. The Evidence of the Risks

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[4] The phrase "adoption agencies" should be understood as including all entities and individuals who place children for adoption, whether public or private, organizational or individual, religious or nonsectarian.

[5] For a discussion of the tort of wrongful adoption, see Jennifer Emmanuel, Note, *Beyond Wrongful Adoption: Expanding Adoption Agency Liability to Include a Duty to Investigate and a Duty to Warn*, 29 GOLDEN GATE U.L. REV. 181 (1999).

[6] Jesus Palacios and David M. Brodzinsky, *Recent Changes and Future Directions for Adoption Research* in PSYCHOLOGICAL ISSUES IN ADOPTION: RESEARCH AND PRACTICE 257, 262 (David M. Brodzinsky and Jesus Palacios, eds., Praeger Publishers 2005). As will be seen, researchers differ in their conclusions as to the rates of risk in adopted and nonadopted populations.

Before we adopted our son, it would never have occurred to us that adopted children were any different from biological children in any fundamental way. Indeed, the agency's efforts were dedicated to the proposition that adopted children are the same as nonadopted children, they just enter the family differently. Our state of ignorance was destined not to last. As the problems we and our son confronted spiraled into ever more serious and incurable realms, my husband and I started to investigate special educational and residential alternatives that could address our son's increasingly pronounced special needs. When we asked what percentage of children--at the school for learning disabled children with concomitant emotional problems, or in the therapeutic boarding school for children with worse disabilities and more serious mental health issues--was adopted, the answers ranged from 40 to 80 percent. Such uniformity of experience eradicated any possibility of coincidence or happenstance, and I started to investigate whether others had undergone the same revelation. The existence of this article shows that we found we were not alone. As one author points out:

> As my daughter turned fifteen, we had only one key left on the ring: an attorney specializing in education law, who could help [our adopted daughter] get into the proper therapeutic milieu, a residential treatment program. He told us, "So many of my clients are adopted, I don't even ask anymore." The comment jolted me–but also confirmed what I already suspected after years of noting a disproportionate number of adoptive parents at special camps and support groups, and in doctors' waiting rooms.[7]

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[7] Rubin, *The Fallout from a Less Than Perfect Beginning*, supra note 3, at 123.

My husband and I have spent years receiving the same information. If we had known what the general risks were when we adopted our outwardly healthy son, we might well have done it anyway–at the time I would have vehemently rejected and been repelled by any argument that nurture could not defeat nature, whatever the nature was, although I had not, of course, seen the data and was unaware of their existence or of the evidence that had caused the studies to be performed in the first place. Certainly I cannot now imagine life without my son. But at least we would have known what we were getting into, and might have been spared time misspent looking for solutions that were the equivalent of shooting peas at an airplane. We would have been more realistic and would not have suffered the death of a hope we would have known better than to have. Perhaps most importantly, and as the most injurious part of our ignorance, we might have entered the counseling process sooner and headed off or at least reduced the impact of some of the issues that subsequently arose. One author points out:

> Rearing an adopted child is more difficult than many adoptive parents would like to admit. Many would like to believe that there is no difference between rearing a biological child and rearing an adopted child. This belief, although it may be well-intended, is counterproductive.[8]

As time goes by, the problems can become increasingly intractable. "When parents wait until adolescence to seek treatment for their

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[8] NANCY NEWTON VERRIER, COMING HOME TO SELF: THE ADOPTED CHILD GROWS UP 296 (Gateway Press, Inc., 2003)

children, the work can be very difficult."[9] The failure to inform parents of the risks they confront can be harmful in preventing parents from seeking solutions sooner, problematic in the lack of postadoption services, and tortious to the extent that it represents an effort by adoption agencies to avoid the truth. "It is well recognized in the adoption field that adequate post-adoption services do not exist, yet are critical for the well-being of adoption triad members."[10] Refusal to confront the risks may be in part responsible for this dearth of services. In any event, had we known of the risks involved, the total sum of suffering–ours and his–would in all probability have been substantially reduced.

Informed consent doctrine and the commitment to individual decision making that it represents require that adoptive parents be informed of the risks that adoption brings with it, and not be left to uncover them on their own when the child has become a teenager. Such information as there is should be disclosed. If that leads to fewer adoptions, then so be it: adoptive parents should not be sacrificed on the altar of the agencies' need to find homes for their children.

A. The Literature

As I was beginning work on this article, the *New York Times* published a piece that related all too closely to this topic. The article, "The

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[9] *Id.* at 403.

[10] Jesus Palacios and David M. Brodzinsky, *Recent Changes*, *supra* note 6 at 267. The adoption triad is the child, the biological mother, and the adoptive parent(s).

DNA Age: That Wild Streak? Maybe It Runs in the Family"[11] discussed the growing scientific view that many behaviors–including risk-taking–are genetic. As one study demonstrated, a group of mice without the particular gene "pranced unprotected along a steel beam instead of huddling in safety like the other mice."[12] Such evidence of a genetic foundation for central behavioral differences is accumulating. As Paul Rabinow, an anthropologist at the University of California, Berkeley, pointed out, "[m]ore and more stories about who we are and how we live are becoming molecular."[13]

It is clear that many, and probably most, forms of mental illness and learning disabilities are genetically linked, if not determined. Psychobiologist Steven Pinker points out that

> Autism, dyslexia, language delay, language impairment, learning disability, left-handedness, major depressions, bipolar illness, obsessive-compulsive disorder, sexual orientation, and many other conditions that run in families, are more concordant in identical than in fraternal twins, are better predicted by people's biological relatives than by their adoptive relatives, and are poorly predicted by any measurable feature of the environment.[14]

While this does not explain the higher incidence of mental health and learning issues in adopted children, it does mean that there is a biochemi-

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[11] Amy Harmon, *The DNA Age: That Wild Streak? Maybe It Runs in the Family*, N.Y. TIMES, June 15, 2006 at A1.

[12] *Id.*

[13] Quoted in *id.*

[14] STEVEN PINKER, THE BLANK SLATE: THE MODERN DENIAL OF HUMAN NATURE 46 (Penguin Books 2003) (2002). *See also* Remi Cadoret, *Genetic-Environmental Interaction in the Genesis of Aggressivity and Conduct Disorders*, 52 ARCH. GEN. PSYCHIATRY 916, 920 (1995) ("[I]n the absence of a biologic parent with antisocial personality disorder, there is no

cal basis for many of the problems associated with adopted children. With respect to these problems, the adoptive family has no chance of becoming the tree to its adopted children.[15] Presumably any genetically based mental illness or learning disability would have appeared in the child whether adopted or not; what is unclear is why the rate of such problems is so much higher in adopted populations than in nonadopted ones.

For various reasons that will emerge below, a substantial percentage of the evidence of risks of learning disabilities and mental illness in adopted children is anecdotal. This does not make it any less real. Nor does it mean that there is no obligation to disclose it. There may be no mammoth studies, no systematic explanation of why so many adopted children have learning disabilities and suffer from mental illnesses. Nevertheless, prospective adoptive parents are entitled to the best evidence that there is. The fact that there is no better source of information may be explained in any number of ways, from the privacy problems inherent in doing prospective studies of adopted children, to the political incorrectness of the view that human behavior has an enormous biological component, to the reluctance of adoption agencies to generate answers to questions that they would much prefer not be asked in the first place. It is hard to work up any enthusiasm for–or to believe in the necessity of per-

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correlation between adoptee outcome and adverse adoptive home environment.").

[15] Unlike the situation with biological children, the IQ scores of children who are unrelated to each other but raised in the same family are "barely correlated." PINKER, supra

forming–a study when you do not want the results.

Nancy Newton Verrier, the parent of a daughter adopted at three days of age and a non-adopted daughter, began her search for the reasons behind her adopted daughter's problems as a graduate student. She reflects:

> According to 1985 statistics used by Parenting Resources of Santa Ana, California, although adoptees at that time comprised 2-3% of the population of this country, they represented 30-40% of the individuals found in residential treatment centers, juvenile hall, and special schools. They demonstrated a high incidence of juvenile delinquency, sexual promiscuity, and running away from home. They have had more difficulty in school, both academically and socially, than their non-adopted peers. The adoptees referred for treatment had relatively consistent symptoms, which are characterized as impulsive, provocative, aggressive, and antisocial.[16]

Ms Verrier points out that prospective adoptive parents are not informed that their future children, irrespective of individual family history, are at a much higher risk of problems than non-adopted children for reasons tied to her view that "[p]roviding honest information and counseling. . .to adoptive parents about the special problems of being an adoptive family, is a conflict of interest for people making money in adoption."[17] Perhaps a slightly less cynical view would lead to the conclusion that those who place children for adoption run the risk of deterring adoptions if they inform parents of the intractable risk of future learning and mental

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note 13, at 47.

[16] NANCY NEWTON VERRIER, THE PRIMAL WOUND: UNDERSTANDING THE ADOPTED CHILD, at xv (Gateway Press 2004) (1993).

[17] Id. at 114.

health problems, which in itself presents a conflict of interest if one is dedicated to placing children for adoption. Such conflicts, however, should not be resolved by withholding information that is necessary for the prospective parents to make an informed decision. A doctor may be concerned that a patient will turn down a procedure that the doctor feels is necessary if the patient is informed of the risks; this is never enough to warrant withholding that information.[18] It is the patient's decision; so also it should be the parents'. "Every potential adoptive couple needs to be informed about the primal wound [of adoption] and the impact it will have on them, their child, and their child's biological mother."[19]

Ms Verrier thus concludes that adoption itself embodies an ineluctable risk factor for future serious problems. She is far from alone in that view. As another author points out:

> "If. . . there is an increased psychosocial risk in being adopted, we might expect higher rates of referral to child psychiatric and mental health clinics for children adopted as babies compared to the general population of children. This, in fact, appears to be the case."[20]

The author believes that the stresses associated with adoption create their own "psychosocial risk factor" that attaches to the fact that one was adopted as an infant.[21] Thus, even without additional risks of learning disabilities and mental illness, the mere fact that one is adopted itself is a

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[18] For a further discussion about what a doctor must tell his patient, see section on Informed Consent, *infra*.

[19] VERRIER, *supra* note 17, at 220 (italics omitted).

[20] DAVID HOWE, PATTERNS OF ADOPTION: NATURE, NURTURE AND PSYCHOSOCIAL DEVELOPMENT 21 (Blackwell Science, 1998).

time bomb that is likely to go off at some point in the child's development. This view has been recently corroborated in BENEATH THE MASK: UNDERSTANDING ADOPTED TEENS.[22] In the view of the authors of this book, adolescence is the trigger for the fact of the adoption itself to create chaos in the lives of the child and his or her family.

> If a therapist sees adolescent patients, it is likely the therapist will encounter adoptees. In fact, about one third of adolescents referred for psychotherapy are adopted. This finding has been confirmed in several studies. However, only 2 percent of the general population is adopted.[23]

In the view of the authors of this book, adoption itself creates a crisis for the adolescent. The book is replete with examples of adolescents referred to The Center for Adoption Support and Education (C.A.S.E.)[24] for treatment; the adoption itself proves to be the trigger for the appearance of many of the problems recounted in the case histories presented.

The authors of THE PRIMAL WOUND and BENEATH THE MASK set forth anecdotal evidence to support their view that adopted children have many more learning and mental health problems than nonadopted children. Their view is that the fact of the adoption in itself constitutes an

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[21] HOWE, *supra* note 21, at 66.

[22] DEBBIE RILEY AND JOHN MEEKS, M.D., BENEATH THE MASK: UNDERSTANDING ADOPTED TEENS (C.A.S.E. Publications, 2005).

[23] RILEY & MEEKS, *supra* note 23, at 1. Other authors have come up with different rates for referral of adolescents. *See, e.g.*, Anu Sharma, Matthew K. McGue, & Peter L. Benson, *The Psychological Adjustment of United States Adopted Adolescents and Their Nonadopted Siblings*, 69 CHILD DEVELOPMENT 791, 799 (1998) (adopted adolescents are referred for counseling at two to five times the rate of nonadopted adolescents). In one study, twice as many adopted adolescents reported receiving counseling as nonadopted adolescents. Brent C. Miller et al., *Adopted Adolescents' Overrepresentation in Mental Health Counseling: Adoptees' Problems or Parents' Lower Threshold for Referral?*, 39 J. AM. ACAD. CHILD ADOLESCENT. PSYCHIATRY 1504, 1506 (2000).

[24] C.A.S.E. is a psychotherapy institute exclusively dedicated to treating adopted chil-

overwhelming risk factor for the problems encountered by many adopted children. This view is not necessarily consistent with the current scientific discoveries surrounding the genetic basis for most forms of learning and mental health problems, although certainly the adoption could itself make genetic tendencies more likely to manifest themselves. But is it the case that adopted children do in fact have more problems than nonadopted children? The systematic generation of statistical evidence that adopted children in fact have more problems than nonadopted children has been hampered by a dearth of reliable and scientific studies. There are, however, some scientific studies, and there is at least some evidence that adopted children have many more learning and mental problems than nonadopted children.

Perhaps the largest study that compared 1587 adopted children and 87,165 nonadopted children through school surveys concluded that "adopted adolescents are at higher risk in all of the domains examined, including school achievement and problems, substance use, psychological well-being, physical health, fighting, and lying to parents."[25] The study further concluded that "more adopted adolescents have problems of various kinds than their nonadopted peers [and that] . . . comparisons of distributions suggest much larger proportions of adopted than nonadopted

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dren and their families. *See* http://www.adoptionsupport.org/ for more information.

[25] Brent C. Miller et al., *Comparisons of Adopted and Nonadopted Adolescents in a Large, Nationally Representative Sample*, 71 CHILD DEVELOPMENT 1458, 1458 (2000) (hereinafter Miller Study).

adolescents at the extremes of salient outcome variables."[26]

In its literature review, the Miller Study pointed out that:

> Some research indicates that adopted adolescents have higher levels of psychological and behavior problems than nonadoptees. Early studies documented that adopted children are several times more likely than their nonadopted peers to be referred for psychological treatment, and some investigators have concluded that adoptees are especially likely to display higher levels of externalizing behaviors and learning disabilities, including attention deficit disorder.[27]

There are, of course, opposing viewpoints, but many of them seem limited to challenging the methodologies of the existing studies and to providing explanations for and recalculating the results of these studies that are inconsistent with the conclusion that adopted children in fact have more problems than nonadopted children. An example of this latter approach is the statement in 1989 by the National Council for Adoption to the effect that "adopted children are overrepresented in psychotherapy and residential treatment because adoptive parents are used to dealing with agencies and seeking professional help."[28] A study of 72 adopted children, with only 30 over age 12, reported "few or no significant differences between adopted and nonadopted children."[29] Adopted children are more likely than nonadopted children "to be referred for mental health treatment. . . .Adoptive parents also have higher than average incomes and education, thus having the resources to seek help for even normal

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[26] Miller Study at 1458.
[27] *Id.* at 1458.
[28] *Id.*

developmental problems."[30] One study summarized evidence that the higher number of adopted children "in psychiatric populations is partially due to referral bias" but also concluded that "adopted children are particularly prone to externalizing disorders, and that a complex blend of genetic, as well as pre-, peri-, and postnatal environmental factors contribute to the manifestation of these disorders."[31]

The Miller Study summarized the existing studies as follows: "there is a consensus that adopted children are overrepresented in psychological therapy and residential treatment programs. This could be because more adopted children have problems, because adoptive parents are more likely to take adopted children for treatment, or both."[32] One of the goals for the Miller Study was to compare adopted and nonadopted adolescents in a large and nationally representative sample, which was accomplished by including 1587 adopted children and 87,165 nonadopted children.

While a detailed summary of this study is beyond the scope of this article, some of the conclusions are worth stressing. The results suggested "a generalized adoption effect that tends to be more negative for boys than for girls."[33] The proportion of adoptees grows as one ap-

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[29] *Id.* at 1459. The study involved an extremely small and young study population.

[30] *Id.*

[31] *Id.* at 1459

[32] *Id.* at 1459

[33] *Id.* at 1469. *See also* Devon Brooks et al., *Contemporary Adoption in the United States: Implications for the Next Wave of Adoption Theory, Research, and Practice* in PSYCHOLOGICAL ISSUES IN ADOPTION: RESEARCH AND PRACTICE 1, 14 (David M. Brodzinsky and Jesus Palacios, eds., Praeger Publishers 2005) (controlling for all ethnic, gender, and

proaches the extreme ends of problematic behavior: "A larger proportion of adoptees than nonadoptees is near the negative end of outcome variables; and the closer to the negative end of an outcome variable distribution, the larger the proportional difference is between adoptees and nonadoptees."[34]

> Practically, how meaningful are these adoptee/nonadoptee differences in proportions at the extreme tails of outcome variable distributions? In many psychological or educational assessment situations, individuals who score in the extreme distribution tails (low end of positive variables or high end of negative variables) would be candidates for treatment or intervention. . . .Ratios of adoptee to nonadoptee proportions near these extreme lower distribution tails are 2:1, 3:1, or even larger in the present analyses. . . [35]

The findings in the Miller Study "document that adoptees have more problems than their peers, and the results are remarkably consistent across the positive and negative outcome variables examined."[36] Concerned about the negative implications for adoption that the study clearly adumbrates, the authors state:

> An implication of these findings is *not* that adoption should be discouraged or that adoption is bad for children. Adoption is probably very good, considering the alternatives, for children who are otherwise faced with prolonged foster care or remaining with biological parents who are unable or unwilling to care for them. In this sense, adoption is usually a positive solution to difficult circumstances. One implication, however of acknowledging that adoptees have more problems than nonadoptees . . . might

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racial variables, "in-racially adopted Caucasian males were found to have the worst outcomes of adoptees overall.").

[34] Miller Study at 1471.

[35] *Id*.

[36] *Id*.

> be that adoption policy and practices could be revised to provide adoptive families with more long-term support. Adoptive parents also could be more fully informed about the elevated problems of some adopted children and their families.[37]

The authors conclude with a call for further research:

> The second major limitation of these analyses[38] is that they do not help explain why, as a group, adopted adolescents have more problems. Our results demonstrate, quite convincingly, that adopted adolescents' behavior and functioning are more problematic than the behavior and functioning of their nonadopted peers, but *why*? . . . . [F]uture analyses are likely to reveal that genetic factors and early experiences form a complex mixture of primary causal mechanisms.[39]

Unfortunately, the studies sought by the authors of this report seem not to have been performed, and there are no scientific explanations of why adopted children have more problems than nonadopted ones. Nor are there studies of rates of mental illness in adult adopted populations as compared with nonadopted populations, which would perhaps be the logical corollary for the Miller Study. Many forms of major mental illness do not appear in their victims until young adulthood, an age group that the Miller Study did not include.

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[37] *Id.* It is perhaps worth noting here that children of lower socioeconomic status who are adopted as infants by parents of higher socioeconomic status score 10 to 20 points higher on IQ tests than their biological parents, although their IQ scores are lower than those of their adoptive parents. They also score 10-20 points higher than their biological siblings who remained with their biological families. *See* HOWE, *supra* note 21, at 31-32.

[38] Miller Study at 1472. The first was that the study did not control for the age of the adopted child at placement.

[39] *Id.* In a subsequent article, Dr. Miller discussed in detail some of the methodological challenges in studying adoption using large scale population-based studies. Brent C. Miller et al., *Methodological Issues in Using Large-Scale Survey Data for Adoption Research*, PSYCHOLOGICAL ISSUES IN ADOPTION: RESEARCH AND PRACTICE 233, 246 (David M. Brodzinsky & Jesus Palacios, eds. Praeger Publishers 2005). These were problems not

A recent study[40] challenged the methodological technique of comparing adopted and nonadopted children, arguing that comparing adopted children to nonadopted children is an inherently unequal comparison.[41] The research for this study was performed in Andalusia, Spain. The authors point out that the comparison depends on whether non-clinical or clinical populations are used:

> The former studies [clinical samples] tend to present an image of greater problems and maladjustments in adopted children than in nonadopted children, with a higher incidence of learning and behavioral problems. The latter studies [nonclinical samples] tend to give a less dramatic view of the difference, but they still show adopted children to be a more problematic group than nonadopted children.[42]

In discussing parental responses to their adopted children, the study indicates that "[p]roblems related to hyperactivity are those that stand out among the concerns of adoptive parents, and this seems perfectly consistent with the greater incidence of this problem in these children . . . "[43] Interestingly, parents with children over 16 years of age perceived more difference "in the nature of adoptive family life than parents [with children between 7 and 11 years old]."[44] The authors conclude:

> The second implication of our first section deals with

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shared by the Miller Study data collection techniques.

[40] Jesus Palacios & Yolanda Sanchez-Sandoval, *Beyond Adopted/Nonadopted Comparisons* in PSYCHOLOGICAL ISSUES IN ADOPTION: RESEARCH AND PRACTICE 117-144 (David M. Brodzinsky & Jesus Palacios, eds. Praeger Publishers 2005).

[41] Why this is the case is unexplained, unless the assumption is being made that adopted children are different in some way.

[42] Palacios & Sanchez-Sandoval, supra note 41, at 118-119.

[43] *Id.* at 131.

[44] *Id.* at 134. This supports the view that adolescence is a particularly traumatic time for adopted children, over and above the normal problems that adolescence brings.

> the "love is not enough" message. If there was a time when idealistic views were held about adoption as a solution for all problems of the adoptees. . . that time is now over. No doubt, there are many crucial problems and emotional wounds that love can heal, and this is also true for adoption. But in order to deal with their children's behavior problems, chronic illnesses, special needs, hyperactivity, impulsivity, school difficulties, feelings of loss, and so on, adoptive parents very often need advice and support, and the adoptees may also need . . . specific professional support . . . .Our postadoption services should be more sophisticated and more readily available for those who need them, both parents and children.[45]

The study concludes with a call for researchers to put their results in a form that can be readily disseminated to and understood by those who need it.[46]

Adopted children, particularly boys, seem at much higher risk for Attention Deficit Hyperactivity Disorder than nonadopted children.

> [I]n fact, if statistics from specific diagnostic subgroups within clinic populations are extrapolated to the general population of adopted children and adolescents, the results are startling, indeed. Extrapolating from the findings . . . for example, suggests that 23 percent of adopted children (36 percent of boys and 14 percent of girls) would be expected to have ADHD. This figure is several times greater than the rate of ADHD in the general population, which is generally estimated to be between 3 and 5 percent[47].

While it is possible that adopted children are more frequently diagnosed with learning or mental health problems because of a "relatively low threshold for psychiatric referral [among adoptive parents,"

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[45] *Id.* at 141-42.

[46] *Id.* at 142.

[47] Barbara D. Ingersoll, *Psychiatric Disorders Among Adopted Children: A Review and Commentary*, 1 ADOPTION QUARTERLY 57, 58 (1997).

> [M]ost of the available evidence indicates that adopted children come to professional attention at higher-than-expected rates in part because: (a) they manifest a higher incidence of psychiatric problems than do non-adopted children; and, (b) their problems are mainly of the externalizing kind, which adults find annoying and aversive.[48]

There are studies that conclude that there are few differences between adopted and nonadopted children, or that reject the inferences from existing studies that lead to the conclusion that there are such differences. One such study points out that existing literature disagrees as to the extent to which adopted children are in fact over-represented clinical populations, and rejects any conclusions on the grounds that these inconsistencies themselves make it impossible to draw any.[49] This study points out that there are barriers to performing reliable studies, including confidentiality concerns, the absence of reporting requirements, and the low rate of adoption, all of which combine to foil efforts to perform any studies from which reliable conclusions may be drawn.[50] Even this study, however, notes that the "differences found between adopted and nonadopted children in terms of emotional and behavior problems are statistically significant . . . "[51]

Another study noted that

> [A]dopted youth were more likely to show ASB [anti-

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[48] *Id.* at 62.

[49] Ann E. Brand and Paul M. Brinich, *Behavior Problems and Mental Health Contacts in Adopted, Foster, and Nonadopted Children*, 40 J. CHILD PSYCHOL. PSYCHIATRY. 1221, 1222 (1999).

[50] *Id.* at 1222.

[51] *Id.* at 1226.

> social behavior], but the effect was not statistically significant. . . .When the adoption status x gender interaction term was added for NAASB [non-aggressive antisocial behavior] . . . the interaction effect was significant, as was the adoption status effect. However, the additional variance explained on this last step was only .2 percentage points.[52]

This study stated that adoption itself is not the sole source of the behavioral problems that many adoptees exhibit, but challenged its own data and encouraged the availability of postadoption services "tailored to the needs of adoptees [and their families]."[53]

B. The Paucity of Literature

While some work on the effects of adoption and risks in adopted populations has been done, more work is needed. Considering the numbers of adopted children in our society and the rate at which problems arise, it is perhaps surprising that more studies have not appeared on the subject and that the existing studies are so limited in research populations. Older populations need to be studied, for example. Many major mental illnesses manifest themselves in young adults, which mean that studies of young children will not reveal information about their mental health as adults. Larger populations need to be studied, as well. If between two and three percent of the population in the United States is adopted, it is concomitantly clear that there are many adopted persons and adoptive families that have not been found or studied.

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[52] Harold D. Grotevant et al., *Antisocial Behavior of Adoptees and Nonadoptees: Prediction from Early History and Adolescent Relationships*, 16 JOURNAL OF RESEARCH ON ADOLESCENCE 105, 126 (2006).

The logical sources of statistical information for further study would be adoption agencies. Thus far, their participation in generating data has been minimal at most. There are, as suggested above, several possible reasons for what looks like reluctance on their part. First, and the least problematic, the agencies might be concerned about the privacy of their families. This objection is so readily solved as to render it disingenuous. There would clearly be privacy issues if agencies, without prior consent, supplied identities of adoptive families to scientists seeking to perform statistical analyses on the status of the adopted individuals. These issues could readily be eliminated by one of several techniques. First, families could be asked to consent to participation in studies. In all honesty, we would have refused to participate in such a study–but then, we had not been informed of the risks of adopting a child in the first place. Had we been so informed, and had we proceeded with the adoption, we might well have agreed to participate in studies of adoption, particularly if what turned out to be needed services were provided as part of the study.[54]

Another way to eliminate privacy concerns lies in anonymity. The surveys could be given to the agency, and the agency could send them to the participants. Upon their return to the agency, the agency could supply the completed surveys to the scientists, making sure that all

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[53] *Id*. at 128.

[54] Our adoption agency provided no follow-up services of any kind beyond the first couple of years.

identifying information was first removed. The scientists would, of course, pay the costs of this agency work. Those families willing to be identified to the surveyors could also be located through this process.

Second, agencies might be unwilling to provide the support services that the surveys might themselves suggest were necessary. Many of the studies discussed above call for enhanced postadoption services; it is possible that more studies would suggest the need for more services as a general matter. The surveys would moreover disclose to the agency that a particular family was struggling in some way. Thus, the surveys themselves might reveal a need for support services in particular cases even if not more generally, and the agencies might be obligated to provide them. This would be expensive, and might lead to disruptions in the relationships between the agencies and their clients.

Third, and most problematic, the agencies might not want the answers that the study might generate. Once it is scientifically and inarguably proven that adopted children suffer from a higher rate of problems as children and a higher rate of mental illness as adults, as most of the evidence currently available seems to suggest, the case for nondisclosure of such risks would dissipate. It would be impossible to contend that the studies were equivocal or that there is little to no evidence that adopted children are any different from any other children and to rely on this contention to support nondisclosure. Clearly, such answers would necessitate changes in the adoption world.

In any event, the literature is what it is. At the least, it confirms

the impressions of adoptive parents that adopted children have more problems than nonadopted children. Knowledge of such literature can–and did, in my case–provide a sense of community (if only after the fact) with other adoptive parents. Agencies cannot be ignorant of the literature, but do not disclose the information in it to prospective parents. There are risks that prospective adoptive parents would want and need to know about in their own decision-making process. Such knowledge might deter adoptions, a result that would be anathema to adoption agencies for both financial and humanitarian reasons. But, as the next section discusses, the decision is not the agencies' to make. They should be required by the law of informed consent to provide such information to couples and individuals seeking adoption.

II. Informed Consent in General

The doctrine of informed consent developed in the medical arena. The doctrine centers on the view that all persons are autonomous and therefore endowed with the right to make their own decisions about their own bodies. It requires that doctors disclose to their patients all risks inherent in a proposed treatment which are sufficiently material[55] such that a reasonable patient would take them into account in deciding

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[55] Harbeson v. Parke Davis, Inc., 746 F.2d 517, 522 (9th Cir. 1984) (stating health care providers must provide individuals with any material information necessary to make intelligent decisions); Canterbury v. Spence, 464 F.2d 772, 786-87 (D.C.Cir. 1972) ("The test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked"), *cert. denied*, 409 U.S. 1064 (1972); Smith v. Shannon, 666 P.2d 351, 354 (Wash. 1983) ("A necessary corollary to this principle is that the individual be given sufficient information to make an *intelligent* decision.")

whether to undergo treatment.[56] This disclosure must encompass both the significant general risks of a particular procedure or course of treatment in addition to the risks unique for that particular patient.[57] This required disclosure, enforced through tort law and statute, is based on the fundamental principle that people are entitled to make decisions about their own medical treatment.[58]

Exceptions to the duty to disclose are limited. Doctors are excused from obtaining consent from patients who are unconscious, incompetent or in need of emergency care.[59] The doctrine of informed consent also does not require doctors to disclose risks that are unknown,[60] commonly understood to be inherent in a particular procedure, or those that

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[56] *See* Petty v. United States, 740 F.2d 1428, 1436 (8th Cir. 1984) (noting informed consent under patient rule standard requires that "individual[s] . . . be advised of the inherent and potential hazards of the proposed treatment, any alternative methods of treatment, the risks attendant to such alternatives, and the likely results of remaining untreated."); Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972) (stating there is duty to disclose other "available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."). *See also Canterbury v. Spence*, 464 F.2d at 787-788 ("The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated); Cowman v. Hornaday, 329 N.W.2d 422, 425 (Iowa 1983) (stating the "duty to disclose has been held to include information relating to the nature of the ailment, the nature of the proposed treatment, the probability of success of the contemplated therapy and its alternatives, and the risk of unfortunate consequences associated with such treatment); Jaskoviak v. Gruver, 638 N.W.2d 1, 7 (N.D. 2002) (noting that since *Canterbury v. Spence*, courts have "tended to favor a duty to disclose all material information, that is, information the physician can reasonably expect a patient would want to consider in determining whether to undergo the medical procedure.").

[57] *See Cobbs v. Grant*, 502 P.2d at 10 (noting doctors owe patients duty of reasonable disclosure of potential risks inherent in a treatment).

[58] *Id.* (noting doctors bound by duty to disclose other alternative treatments and dangers involved in each). *See also* Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (N.Y. 1914).

[59] *E.g. Canterbury v. Spence*, 464 F.2d at 788-89 (D.C.Cir. 1972) (noting emergency situations are exception to rule of disclosure), *cert. denied*, 409 U.S. 1064 (1972); Shine v. Vega, 709 N.E.2d 58, 64 n. 15 (Mass. 1998) (citing unconsciousness as one emergency exception that excuses doctors from obtaining informed consent of patient); Cross v. Trapp, 294 S.E.2d 446, 455 n. 6 (W.Va. 1982) (noting doctors must be free to exercise best medical judgment when treating life-threatening injury due to emergency).

[60] Shadrick v. Coker, 963 S.W.2d 726, 733 (Tenn. 1998) (stating doctors not required to

are already known by the patient.[61] Another exception to informed consent arises when fully disclosing the risks to a patient is considered medically inadvisable,[62] such as where the disclosure will result in a harmful physical, emotional or psychological effect on the patient which would outweigh any benefit to fully informing that patient.[63] The risk that a fully informed patient will decline treatment that the doctor believes necessary is not enough, by itself, to warrant nondisclosure.[64]

In some jurisdictions, the standard of what a doctor must disclose is governed by a reasonable patient standard. This means that doctors must provide enough information to satisfy what a reasonable patient would want to know under the circumstances.[65] While there is some de-

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disclose every possible risk of treatment, only those that are known and likely).

[61] *Id.* (noting "health care providers are generally not required to disclose risks that are not material, such as those that are extremely unlikely to occur or one that a reasonable patient would not care to know due to its insignificance [or] . . . risks that are obvious or already known by the patient. . ."); *see also* Calwell v. Hassan, 925 P.2d 422, 432 (Kan. 1996) (stating doctors need not warn patients about risks which patients already know about).

[62] *See* Crain v. Allison, 443 A.2d 558, 563 (D.C. 1982) (stating doctor is excused from obtaining informed consent when disclosing information will threaten patient's well-being); Woods v. Brumlop, 377 P.2d 520, 525 (N.M. 1962) ("[A]nother exception is where an explanation of every risk attendant upon a treatment procedure may well result in alarming a patient. . . [and] such [a] disclosure may result in actually increasing the risk by reason of the psychological results of the apprehension itself).

[63] *Shadrick v. Coker*, 963 S.W.2d at 733 (holding full disclosure not necessary when nformation would make patient unduly alarmed and "jeopardize his physical or emotional well-being.").

[64] *Canterbury v. Spence*, F.2d at 789 ("The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed . . . [and the law] does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.").

[65] Wheeldon v. Madison, 374 N.W.2d 367, 374 (S.D. 1985) (stating "an increasing number of courts have rejected the [former] majority rule, opting instead in a favor of a patient-oriented standard."). *Accord*, *Canterbury v. Spence*, 464 F.2d at 786-87 ("[T]he patient's right of self-decision shapes the boundaries of the duty to reveal."); *Crain v. Allison*, 443 A.2d at 562 ("The test for mandatory disclosure of information on treatment of the patient's condition is whether a reasonable person in what the physician knows or should know to be the patient's position would consider the information material to his decision."); Cobbs v. Grant, 502 P.2d 1, 10 (Cal. 1972) ("Unlimited discretion in the physician is irrecon-

bate over whether the disclosure should be measured by what a reasonable doctor would disclose or what a reasonable patient needs to know,[66] these standards tend to merge because a reasonable doctor should disclose what a reasonable patient needs to know. The doctor is always, of course, held to the standard of knowledge of a reasonable doctor in the circumstances in terms of factual knowledge of the risks. In other words, a doctor is not obligated to disclose a risk about which a reasonable doctor would not know.

As well as by tort law, doctors are guided by a professional code of ethics that mandates what they must disclose to their patients and governs the doctor-patient relationship.[67] The doctrine of informed consent is designed to give patients greater autonomy over decisions that affect their lives and to allow them to fully participate in their health care decisions by ensuring they have all the pertinent information when making vital decisions.[68] In addition to their informed consent obligations, doc-

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cilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgably consents to be subjected."); Logan v. Greenwich Hosp. Ass'n, 465 A.2d 294 (Conn. 1983) (discussing shift after *Canterbury v. Spence* away from professional standard to that of patient oriented standard of disclosure, or what reasonable patient would want to know under the circumstances.) *See also Informed Consent*, *American Medical Association: Helping Doctors Help Patients*, available at http://www.ama-assn.org/ama/pub/category/4608.html (discussing informed consent from perspective of what doctor must tell patient).

[66] *Canterbury v. Spence*, 464 F.2d at 786 ("some [courts] have measured the disclosure by 'good medical practice,' others by what a reasonable practitioner would have bared under the circumstances. . . . [But] [a]ny definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected himself."). The court further noted that "[t]he scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision." *Id.* (internal citations omitted).

[67] *See Code of Medical Ethics*, available at http://www.ama-assn.org/apps/pf_new/pf_online?category=CEJA&assn=AMA&f_n=mSearch&s_t=&st_p=&nth=1& (discussing guidelines of disclosure required by doctors).

[68] *See Canterbury v. Spence*, 464 F.2d at 780 ("The root premise is the concept, funda-

tors have a fiduciary obligation to their patients to avoid conflicts of interest that might affect their judgment.[69] As with all professions, if the doctor does not treat the patient, it affects his or her fee: a surgeon does not get paid for not operating, for example, just as an attorney does not get paid for not suing someone. All professionals who face this form of conflict of interest are equally obligated to put the welfare of their clients/patients first, ahead of their own.[70]

Other types of professionals, such as lawyers and certain financial industry professionals, are also subject to specific "informed consent"-like responsibilities, although that responsibility might be better characterized as a duty to disclose material information necessary for informed decision making. Securities brokers, for example, function as fiduciaries to their clients and are therefore in a position of trust and confidence.[71] When a

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mental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . .") (quoting Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (N.Y. 1914); Smith v. Shannon, 666 P.2d 351, 354 (Wash. 1983) (noting informed consent doctrine is premised on fundamental principle that competent individual is entitled to determine what shall be done to his or her own body).

[69] *Moore v. Regents of University of California*, 271 Cal.Rptr. 146, 154 (Cal. 1990) (holding that where doctor was performing procedure on patient that was of research and economic value to him, doctor had duty to disclose the research and economic value to patient, because "the existence of a motivation for a medical procedure unrelated to the patient's health is a potential conflict of interest and a fact material to the patient's decision.").

[70] HMOs are somewhat cynically designed to deter treatment by making it in doctors' financial self interest not to treat. *See* Barry Furrow, et al., LIABILITY AND QUALITY ISSUES IN HEALTH CARE 520 (Thomson/West 2004).

[71] *See* Sexton v. Kelly, 200 P.2d 950, 954 (Or. 1948) (stating broker, as agent for principal "occupied a fiduciary relation[ship] and was required to act with the utmost good faith and loyalty in her interest, and . . . [he had affirmative duty to communicate] to her all material information to her advantage which. . . he possess[ed]. . ."); Gillmore v. Morelli, 472 N.W.2d 738, 739 (N.D. 1991) (holding a "broker's duty to an employer is essentially the same fiduciary duty that an agent owes to a principal."); Sigurdson v. Lahr & Lahr, Inc., 299 N.W.2d 792, 796 (N.D., 1980) (stating broker is under legal obligation to disclose material facts which might affect his principal's interests). *See also* 12 C.J.S. *Brokers* §41 (2006);

fiduciary relationship exists between a professional and his or her client, the professional is obligated to disclose material information to that client which the fiduciary possesses and the client is entitled to know.[72] It is the fiduciary nature of the relationship that creates the obligation of disclosure. When the law imposes a duty on one party to disclose all material facts known to that party and not known to the other, silence or concealment in violation of this duty coupled with the intent to deceive the other party amounts to fraud.[73]

Real estate agents and brokers are also generally required to disclose material information to their clients. Generally speaking, a real estate agent's or a broker's liability to his or her client is founded on the law of agency.[74] Brokers, as agents, ordinarily owe a fiduciary duty to their principals.[75] Among a broker's duties are the obligations to account

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8 AM.JUR. *Brokers* §86 (2006).

[72] United States v. Szur, 289 F.3d 200, 210 (2d Cir. 2002) ("[A] fiduciary owes a duty of honest services to his customer, including a duty to disclose all material facts concerning the transaction entrusted to it.") (quoting United States v. Chestman, 947 F.2d 551, 565 (citing Chiarella v. United States, 445 U.S. 222, 228 (1980)).

[73] *See e.g.*, *Wheeler v. Missouri Pac. R. Co.*, 42 S.W.2d 579, 583 (Mo. 1931) ("Where the law, by reason of the relation of the parties . . . or other circumstances, imposes a duty upon one of them to disclose all material facts known to him and not known to the other, mere silence in violation of this duty, with intent to deceive, will amount to fraud."); Perkins v. Marsh, 37 P.2d 689, 690 (Wash. 1934) (stating concealment by one party of material fact which he is bound to disclose is actual fraud).

[74] *See Proctor v. Holden*, 540 A.2d 133, 141 (Md. App. 1988) (stating broker's liability is founded on law of agency). Agency is defined as ". . . the fiduciary relation which results from the manifestation of consent by one person to another that the other shall act on his behalf and subject to his control, and consent by the other so to act." Restatement (Second) of Agency §1 (1958). "Three elements are integral to any agency relationship: (1) the agent is subject to the principal's right of control; (2) the agent has a duty to act primarily for the benefit of the principal; and (3) the agent holds a power to alter the legal relations of the principal." *Id.* at §§12-14 (1958).

[75] *Proctor v. Holden*, 540 A.2d 133, 141 (Md. App. 1988) (noting broker, as agent for principal, owes fiduciary duty of "diligence, care, loyalty, disclosure and the like.").

for all funds or property that belong to the principal[76] and to refrain from acting in any way that is adverse to the principal's interests or done solely to advance the broker's own personal interests.[77] A broker must not engage in fraudulent conduct toward his or her principal.[78] More specifically, a broker has an affirmative duty to make a full and frank disclosure of any information he or she possesses that may be to the principal's advantage.[79] Real estate brokers, too, generally act as fiduciaries to their principals[80] and must therefore act with "fidelity and good faith"[81] and in the best interests of their principals.[82] Real estate agents are under a both a legal and moral obligation to faithfully serve their clients.[83]

Lawyers, too, like doctors, brokers, real estate agents and other financial professionals, also have special obligations to their clients and have guidelines that govern those responsibilities.[84] The attorney-client

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[76] *See* 12 AM. JUR. 2D *Brokers* §113 (2006); Restatement (Second) of Agency §382 (1958).

[77] *See* 12 AM. JUR. 2D *Brokers* §111 (2006).

[78] *See Id.* at §114.

[79] *See Id.* at §116.

[80] *Garren v. First Realty, Ltd.*, 481 N.W.2d 335, 337 (Iowa 1992) (stating real estate brokers are fiduciaries to principals).

[81] *Garren v. First Realty, Ltd.*, 481 N.W.2d at 337 (noting fiduciary relationship mandates trust and loyalty between fiduciary and principal).

[82] *Sonnenschein v. Douglas Elliman-Gibbson & Ives*, 753 N.E.2d 857, 860 (N.Y. 2001) ("[A] real estate broker is a fiduciary with a duty of loyalty and an obligation to act in the best interests of the principal.") (quoting Dubbs v. Stribling & Assocs., 752 N.E.2d 850, 852 (N.Y. 2001).

[83] *Darby v. Furman Co., Inc.*, 513 S.E.2d 848, 849 (S.C. 1999) (noting fiduciary relationship imposes "a high moral duty to give loyal service to the principal."). The court further held that "the duty of an agent to make full disclosure to his principal of all material facts relevant to the agency is fundamental to the fiduciary relationship of principal and agent." *Id.* at 850.

[84] *See American Bar Association (ABA) Model Rules of Professional Conduct*, available at https://www.abanet.org/cpr/mrpc/model_rules.html. In 1983, the ABA adopted the *Model Rules of Professional* Conduct. *See* PREFACE, MODEL RULES OF PROF'L CONDUCT (2006), available at http://www.abanet.org/cpr/mrpc/preface.html. Since the ABA is a private organization, its ethics rules generally do not have the force of law, so the *Rules* have no legal effect

relationship creates a fiduciary duty, and attorneys have one of the "highest fiduciary duties imposed by law."[85] Attorneys are required to "deal fairly, honestly and with undivided loyalty" to their clients.[86] The nature of the attorney-client relationship is such that attorneys are responsible for ". . . operating competently, safeguarding client property and honoring the client's interests over the lawyer's."[87] Lawyers must also maintain the confidential information of their clients[88] and must avoid conflicts of interest.[89] A lawyer has in a conflict of interest when "on behalf of one

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unless they are affirmatively adopted by the controlling jurisdiction. See PREAMBLE AND SCOPE, MODEL RULES OF PROF'L CONDUCT (2006), available at http://www.abanet.org/cpr/mrpc/preamble.html. However, since many state bar associations and state courts have adopted the *Rules*, they do have considerable force, and in cases where they have not been adopted, courts can still use them to guide their decisions. *Id.*

[85] *In re Hayes*, 183 F.3d 162, 168 (2d. Cir. 1999) (". . . the attorney-client relationship entails one of the highest fiduciary duties imposed by law.").

[86] *In re Cooperman*, 633 N.E.2d 1069, 1071 (N.Y. 1994) ("This unique fiduciary reliance ... is imbued with ultimate trust and confidence.").

[87] In re Cooperman, 633 N.E.2d 1069, 1071 (N.Y. 1914)

[88] *See* MODEL RULES OF PROF'L CONDUCT R. 1.6 (2006), available at https://www.abanet.org/cpr/mrpc/rule_1_6.html. The full text of the rule reads:
a) A lawyer shall not reveal information relating to the representation of a client unless the client gives informed consent, the disclosure is impliedly authorized in order to carry out the representation or the disclosure is permitted by paragraph (b).
(b) A lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary:
(1) to prevent reasonably certain death or substantial bodily harm;
(2) to prevent the client from committing a crime or fraud that is reasonably certain to result in substantial injury to the financial interests or property of another and in furtherance of which the client has used or is using the lawyer's services;
(3) to prevent, mitigate or rectify substantial injury to the financial interests or property of another that is reasonably certain to result or has resulted from the client's commission of a crime or fraud in furtherance of which the client has used the lawyer's services;
(4) to secure legal advice about the lawyer's compliance with these Rules;
(5) to establish a claim or defense on behalf of the lawyer in a controversy between the lawyer and the client, to establish a defense to a criminal charge or civil claim against the lawyer based upon conduct in which the client was involved, or to respond to allegations in any proceeding concerning the lawyer's representation of the client; or
(6) to comply with other law or a court order.
Id.

[89] *See* MODEL RULES OF PROF'L CONDUCT R. 1.7, available at https://www.abanet.org/cpr/mrpc/rule_1_7.html. The full text of the rule reads:

> (a) Except as provided in paragraph (b), a lawyer shall not represent a client if the representation involves a concurrent conflict of interest. A concurrent conflict of interest exists if:

client, it is his duty to contend for that which his duty to another client requires him to oppose."[90] The attorney-client relationship is so highly

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(1) the representation of one client will be directly adverse to another client; or
(2) there is a significant risk that the representation of one or more clients will be materially limited by the lawyer's responsibilities to another client, a former client or a third person or by a personal interest of the lawyer.

(b) Notwithstanding the existence of a concurrent conflict of interest under paragraph (a), a lawyer may represent a client if:
(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;
(2) the representation is not prohibited by law;
(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal; and
(4) each affected client gives informed consent, confirmed in writing.

Id.

[90] *See* MODEL RULES OF PROF'L CONDUCT R. 1.8, available at https://www.abanet.org/cpr/mrpc/rule_1_8.html. The full text of the rule reads:

(a) A lawyer shall not enter into a business transaction with a client or knowingly acquire an ownership, possessory, security or other pecuniary interest adverse to a client unless:
(1) the transaction and terms on which the lawyer acquires the interest are fair and reasonable to the client and are fully disclosed and transmitted in writing in a manner that can be reasonably understood by the client;
(2) the client is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel on the transaction; and
(3) the client gives informed consent, in a writing signed by the client, to the essential terms of the transaction and the lawyer's role in the transaction, including whether the lawyer is representing the client in the transaction.

(b) A lawyer shall not use information relating to representation of a client to the disadvantage of the client unless the client gives informed consent, except as permitted or required by these Rules.

(c) A lawyer shall not solicit any substantial gift from a client, including a testamentary gift, or prepare on behalf of a client an instrument giving the lawyer or a person related to the lawyer any substantial gift unless the lawyer or other recipient of the gift is related to the client. For purposes of this paragraph, related persons include a spouse, child, grandchild, parent, grandparent or other relative or individual with whom the lawyer or the client maintains a close, familial relationship.

(d) Prior to the conclusion of representation of a client, a lawyer shall not make or negotiate an agreement giving the lawyer literary or media rights to a portrayal or account based in substantial part on information relating to the representation.

(e) A lawyer shall not provide financial assistance to a client in connection with pending or contemplated litigation, except that:
(1) a lawyer may advance court costs and expenses of litigation, the repayment of which may be contingent on the outcome of the matter; and
(2) a lawyer representing an indigent client may pay court costs and expenses of litigation on behalf of the client.

(f) A lawyer shall not accept compensation for representing a client from one other than the client unless:
(1) the client gives informed consent;
(2) there is no interference with the lawyer's independence of professional judgment or with the client-lawyer relationship; and
(3) information relating to representation of a client is protected as required by Rule 1.6.

valued that the United States Supreme Court has said:

> There are few of the business relations of life involving a higher trust and confidence than those of attorney and client or, generally speaking, one more honorably and faithfully discharged; few more anxiously guarded by the law, or governed by sterner principles of morality and justice; and it is the duty of the court to administer them in a corresponding spirit, and to be watchful and industrious, to see that confidence thus reposed shall not be used to the detriment or prejudice of the rights of the party bestowing it.[91]

This article now turns to the lessons that this body of law can teach to adoption agencies. Prospective adoptive parents approach agencies in hope and as supplicants, desperate for a child, and relying on the agencies

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> (g) A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients, or in a criminal case an aggregated agreement as to guilty or nolo contendere pleas, unless each client gives informed consent, in a writing signed by the client. The lawyer's disclosure shall include the existence and nature of all the claims or pleas involved and of the participation of each person in the settlement.
> (h) A lawyer shall not:
> (1) make an agreement prospectively limiting the lawyer's liability to a client for malpractice unless the client is independently represented in making the agreement; or
> (2) settle a claim or potential claim for such liability with an unrepresented client or former client unless that person is advised in writing of the desirability of seeking and is given a reasonable opportunity to seek the advice of independent legal counsel in connection therewith.
> (i) A lawyer shall not acquire a proprietary interest in the cause of action or subject matter of litigation the lawyer is conducting for a client, except that the lawyer may:
> (1) acquire a lien authorized by law to secure the lawyer's fee or expenses; and
> (2) contract with a client for a reasonable contingent fee in a civil case.
> (j) A lawyer shall not have sexual relations with a client unless a consensual sexual relationship existed between them when the client-lawyer relationship commenced.
> (k) While lawyers are associated in a firm, a prohibition in the foregoing paragraphs (a) through (i) that applies to any one of them shall apply to all of them.

Id. *See also* Jedwabny v. Philadelphia Transp. Co., 135 A.2d 252, 254 (Pa. 1957) (specifying what constitutes conflict of interest).

[91] Stockton v. Ford, 52 U.S. 232, 247 (1850) (discussing nature of attorney client relationship) (internal citations omitted). Other revered thinkers have commented on the nature of the attorney-client relationship. Sir Francis Bacon once said:

> THE greatest trust, between man and man, is the trust of giving counsel. . . . The wisest princes need not think it any diminution to their greatness, or derogation to their sufficiency, to rely upon counsel. God himself is not without, but hath made it one of the great names of his blessed Son: The Counsellor.

Francis Bacon, *Of Counsel*, in THE ESSAYS OF FRANCIS BACON 181 (1846) available at

to help them become parents and depending on those agencies for their expertise and help. Just as doctors, lawyers, and architects, the agencies are professionals who provide a window into a world that is unfamiliar to the parents who approach them.

III. The Right to Know in Adoption

A. Codes of Ethics in the Adoption Professions

The right of informed consent forms part of the law applicable to the professions, but those professions are also governed by codes of ethics. "Adoption of and adherence to a code of ethics is the cornerstone of a profession and differentiates between professional and quasi- or semi-professional practice."[92] If adoption agencies want to be viewed as professionals, they need to adhere to the same principles that require that the surgeon advise against surgery where that surgery is unnecessary and the lawyer advise against legal action where that action would harm the client. Whether or not there is a code of ethics that requires such a result, the law imposes obligations that lead to similar results.

Few social scientists have discussed the ethics applicable to adoption agencies in placing children. One such person is L. Anne Babb.[93] She points out that "[e]thical inquiry has only been reflected in the pro-

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http://www.authorama.com/essays-of-francis-bacon-21.html.

[92] L. Anne Babb, *Ethics in Contemporary American Adoption* in CLINICAL AND PRACTICE ISSUES IN ADOPTION: BRIDGING THE GAP BETWEEN ADOPTEES PLACED AS INFANTS AND AS OLDER CHILDREN 117 (Victor Groza and Karen F. Rosenberg, eds., Praeger Publishing 1998) (hereafter Babb Ethics).

[93] *Id.*

fessional literature of psychology and social work for a scant 20 years."[94]

> Some of the areas that have proved to be challenging for professionals at best, and problematic at worse, are conflict of interest, identifying the client, disclosure of information, responsibility to clients, and maintaining and improving professional competence.[95]

One of the core difficulties identified in this article lies with the conflict of interest between the adoptive parents and the child. As between those two entities, adoption agencies tended to view the child as the priority, leading to the result that "[m]any families felt . . .that they were persuaded [by social workers] to take . . . children against their better judgment."[96] While this study refers largely to special needs adoptions, the disclosure principles applicable to such adoptions should equally apply in all adoptions. It is the existence of risks that creates the duty of disclosure, and if risks exist in all adoptions, all prospective parents should be informed of them. Incidentally, it is possible that biological parents, when informed of the same risks, might decide not to place their children for adoption and subject them to "the primal wound." It would be their right, just as it is the right of prospective adoptive parents to decide against adoption.

The Babb Ethics study points out that there are five professions "commonly involved in adoption: social work, mental health, nursing,

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[94] *Id.* at 117. Of course, she is counting backward from 1998.
[95] *Id.*
[96] *Id.* at 119.

law and medicine."[97] It is perhaps worth pointing out that law and medicine have pre-existing obligations of informed consent and communication with clients, and thus do not need the additional impetus of further legally imposed rules as to disclosure. Doctors and lawyers already owe duties to their patients and clients to inform them of risks.

The "five professions share . . . ethical obligations" that include duties to clients, integrity, and communication.[98] In terms of communication:

> This standard requires professionals to warn clients of adverse consequences of actions or services offered and asks professionals to tell clients about their rights, risks, opportunities, and obligations associated with professional service to them. There was universal agreement that adoption clients should receive accurate and complete disclosure of information about adoption and the adverse consequences of adoption.[99]

One of the problems with this standard in the context of adoption involves deciding on the identity of the client: many respondents viewed the unborn child as the client in the context of infant adoption. Others viewed the biological mother as the client, or the child and the biological mother as the client, while "45% considered the expectant parents, the unborn child, and the prospective adoptive parents [to be] the clients."[100] The problem leaps from the page: the obligations to inform the adoptive parents about the general risks of adoption might lead them to abandon

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[97] *Id.* at 123.
[98] *Id.*
[99] *Id.* at 125.
[100] *Id.* at 128.

the idea of adoption, which threatens the welfare of the baby and the biological mother. This cannot justify failure to disclose, however. Just as the donor of a kidney is entitled to know the risks to them of both the surgery and the long-term impact of having one kidney, even though it might lead to the proposed recipient losing the donation, so also the prospective adoptive parents are entitled to know the long term risks of adoption.

The Babb Ethics study sets forth the following obligations to which adoption professionals should adhere:

1. The adoption professional should explain "[b]oth the positive and negative aspects of adoption for the adoptive parents and the adoptee. . ."[101]

2. "The adoption professional should warn prospective adoptive parents about the possible adverse consequences of adoption. . . .The adoption professional should completely explain the possible long-term effects of separation, loss, and adoption to prospective adoptive parents, including the emotional and psychological effects of adoption for both the adoptee and the adoptive parents."[102]

3. "The adoption professional should provide written information, recommended reading, counseling, and other resources to help adoptive parents understand adoption dynamics."[103]

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[101] *Id.* at 144.
[102] *Id.*
[103] *Id.*

While states license adoption agencies, there is no uniform ethical code applicable to the profession and that would require the information outlined above.[104]

B. Legal Sources of Obligations to Inform in Adoption

This article argues that there are legal obligations of duty and informed consent that require that clients of adoption agencies receive information about adoption itself and the risks that it involves. As was pointed out above, law and medicine already have legal obligations to disclose risks to their clients and patients. These obligations spill over into the other professions involved, created by the nature of the relationship and the presence of information that prospective parents need to know. The duty to disclose is an affirmative way of viewing the obligation to share information; preventing fraud and misrepresentation is the negative. If there is information in the possession of the adoption agency–and this article shows that there is–then withholding this information both violates any duty to disclose and amounts to misrepresentation

This article has demonstrated that there are studies that make it at least arguable that adopted children suffer from higher rates of learning, emotional, and mental health problems than nonadopted children. One of the major and glaring omissions from the literature is evidence that would scientifically explain why the risks are there. There are several possible explanations for the undeniably higher rates of learning disabilities and

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[104] *Id.* at 132.

mental illness in the adopted population than in the nonadopted population. The explanations include the following:

1. That fact that one is adopted is itself a source of trauma and a reality that can produce serious problems as the child reaches adolescence. This possibility cuts across all adoptions, no matter the age or background of the child.

2. Most if not all forms of mental illness and learning disability have a genetic base. For some reason as yet not fully understood or studied, adopted children have higher genetic risk factors for learning disabilities and mental illness. These risks inevitably cause the school and social problems from which adopted children seem to suffer at a higher rate than the nonadopted population.

3. Adopted children have higher genetic risks for learning disabilities, and adoption itself is a source of trauma. These two factors, acting together, produce the higher rates of learning disabilities and mental illness that studies have found in adopted populations.

It is noteworthy that none of these three explanations has anything to do with specific risk factors for the particular child. It is clear that an adoption agency has an obligation to disclose any information that it has or should have relating to the individual child; if it does not, it has committed the tort of wrongful adoption and is subject to suit. But adoption itself seems to bring with it ineluctable risks to all children and separate and apart from individuated risks to the particular child. In the medical arena, doctors are obligated to disclose the risks of medical proce-

dures so that their patients can make informed decisions about what treatment to undergo. In the legal arena, lawyers have an ethical obligation to inform their clients of pertinent risks so that their clients can make important decisions such as whether to settle a case, testify, or plead guilty. As yet, adoption agencies have not been held to a standard that would require that they inform all prospective adoptive parents of the issues that may well be in their future.

Whatever the source of problems in adopted children, adoptive parents should be informed that adopted children demonstrably have a much higher level of learning and mental health problems than nonadopted children. Most adoptive parents greet their new child with joy and with a complete ignorance of the future problems they are likely to confront. Agencies, who have no excuse for not knowing the risks, are clearly the best entities to prepare the new parents for their future crises. If the information deters some parents, they probably should not be adopting in the first place. In any event, adoptive parents need to know that love is not enough and that the problems that their child may develop probably had nothing to do with their parenting. The seeds have already been sown. But knowing what is coming will help both the child and the parents, and may actually help to minimize the damage.

When a couple goes to a genetics counselor prior to becoming pregnant, the counselor has an obligation to inform them of any and all risks that that might be material in their decision making process. An obstetrician has an obligation to disclose not only risks of the specific

pregnancy, but also more general risks, for example if the mother is over a certain age. The important watchword here is disclosure.

Similarly, when a couple goes to an adoption agency seeking to adopt, they are of course entitled to any child-specific information. But they are also entitled to any and all information about general risks, such as the risks discussed in this article. The agency should have a legal obligation to disclose all information that the agency knows or should know about the general risks of adoption. This obligation is underlined and informed by the fact that the majority of prospective adoptive parents has come through the despair of infertility and are particularly apt to discount or ignore any negative information they receive. Prospective adoptive parents are a vulnerable group; adoption professionals should not trade on this vulnerability.

If the information is equivocal, as much of it is, the prospective couple should receive such information; the impact (if any) on their adoption plans is up to them, it is not up to the agency to decide. If this information is not available because its generation has been eschewed by the entities most able to discover it, that in itself is something of a warning flag and should be disclosed. The agency must adhere to a duty to the couple, as well as to the child, and not seek to place a child with a couple that--through ignorance--is ill-equipped to deal with the problems and crises that may, or may not, lie ahead.